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ABSTRACT

The opening section of the document provides a brief perspective of the National Health Service (NHS) in England and Wales, which forms a background for the discussion presented in the rest of the report. The second section, Retrospect, gives a historical survey of the evolution of the NHS from the previous health care supply system, with responsibility placed at the regional and local levels, and maintaining the strong emphasis on general practice. Section Three, Prospect, considers current reforms in the NHS, including discussion of the aims of the reformed service, current strategies for change, and significant omissions from the general strategy. Section Four, Horizons of Quality, focuses on the implications of the concepts of quality and accountability on the people and institutions involved in the NHS and on future policy formation and planning. The fifth section, Reconnaissance on the Educational Front, looks at present available formal and informal education in the health care field, and at the needs for definition of educational objectives, identification of groups to be trained, content to be covered, and the place of the institution as new education and training programs are planned. A review section concludes the document. (SA)

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Centre for Educational Research and Innovation (CERI)

THE BRITISH NATIONAL HEALTH SERVICE

POLICY TRENDS AND THEIR IMPLICATION FOR EDUCATION

by

Gordon McLACHLAN

CE 006711

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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PREFACE

Just as with so many facets of modern society, health care poses major developmental problems. Access to complete health care has come to be regarded as a right, and the last 20 years have seen an explosive growth in national systems of health care. At the present time, they constitute major elements in our society, involving four to six per cent of the labour force and from four to eight per cent of annual expenditure in most OECD Member countries.

Behind these signs of size and growth lie many riddles. Health care has achieved remarkable advances in terms of falling infant death rates, new treatments, and surgical wonders - yet there remain large pockets of society without adequate access to health care, and there is growing dissatisfaction with health care in its individual and human aspects. A lengthening life span and the complexities of modern society have created the need for new approaches to escalating socio-medical conditions such as aging, chronic illness, mental illness, drug abuse, and alcoholism. To sustain the excellence of the present while grappling with these new problems, and to do so within reasonable limits of human and financial resources, is the challenge now facing the health professions.

New answers to new problems in whatever field inevitably call for personnel with different kinds of knowledge and skill. It was with this fact in mind that CERI in 1972 undertook a study of education of the health professions in the context of evolving health care systems, with the financial support of the Josiah Macy, Jr. Foundation.

The study was directed by a Group of Experts appointed by the Secretary-General of the OECD, Mr. Emile van Lennep. From the first, the Group addressed itself to certain basic questions: where are health care systems going, and why? Do these directions put new calls to our patterns for educating the health professions and occupations? Are there models of innovation that deserve to be followed up at national or international level?

The far-ranging results of the Group's study have been published under the title "New Directions in Education for Changing Health Care Systems" (OECD, Paris, 1975). Future health care, in the Group's view, will have a much stronger orientation to individualised,

community-based primary health care. This reorientation will require professional personnel with new understanding and skills in social, psychological and management areas. The effectiveness of the reorientations, and the speed with which it will come, hinge on new partnerships between education and health care - partnerships forged at the regional level, and fostered by national and international policy clarification.

In the course of their study, the Group commissioned a number of special investigations dealing with important aspects of the health care/education interaction. The present document was prepared by Gordon McLachlan, The Nuffield Provincial Hospitals Trust.

J.R. Gass
Director,
Centre for Educational
Research and Innovation

I. PERSPECTIVE

There are in effect three National Health Services operating in Britain covering England and Wales, Scotland, and Northern Ireland. Although the general principles are roughly the same, the scale of operation makes for differences of approach. This particular paper refers to the position in England and Wales.

It is of the essence of an understanding of the National Health Service to recognise that it is not the monolithic structure many people assume. From its inception until now it has consisted of many hundreds of different authorities with varying degrees of independence. The sweep of its responsibilities is enormous, covering health care services of every type for nearly 50 million people; and currently its annual costs are of the order of £2,600 million, the accountability for which is spread over a multitude of individuals and institutions. Apart from the major Act of 1946 which set it up and some minor legislation since, there are various statutory instruments and circulars regulating the administration of the Service. To get a full understanding of how, against seeming logic, it has hitherto failed to develop a more streamlined look, it must also be appreciated that some of the oral undertakings given in 1946 by the Minister responsible during the passage of the Act to allay the fear vigorously expressed of over-bureaucratic action have been honourably kept. This applies particularly to the pledges given with respect to the delegation of authority to the lower tiers of the Service - although admittedly without regard to very well-defined issues.

These safeguards against too much bureaucracy have been responsible certainly for the style and probably also for the somewhat defensive role of the Department of Health and its failure to develop a grand intensive strategy for attack. They probably also account for the apparent piecemeal development of individual subjective policies in response to scientific, social, economic and political pressures instead of a series of cohesive tactical moves relative to a strategic plan developed at the centre. The very nature of the service and the semi-independence of many of the authorities have also prevented the formation of a nationally integrated personnel policy which is probably fundamental to a well-geared career structure, and to a co-ordinated educational response.

All such arrangements, however, are now in the course of change to give effect to the NHS Reorganisation Act 1973, which is designed to unify health services under considerably fewer Health Authorities to allow for more effective management.

It is against this background that the observations in this paper have been made.

II. RETROSPECT

1. HEALTH CARE ORGANISATION AS A SOCIAL POLICY

It is only since the Second World War that health care organisation has come to be seen as a specialised subject on its own, to be talked and written about widely as an issue of social policy at national level. Previously, the organisation of health care services was virtually regarded as something best left to local initiatives within the public administration sector, to be regulated as necessary by enactments under public health policy. In the case of the medical profession it came then to be treated as a subject in the specialty field of public health. During the last 40 years, because of the expansion of technological resources in the practice of medicine, hospital administration has steadily come to the fore as a separate profession; but even so, the circumstances of the times have now forced it to extend its horizons into the wider field of health services administration.

2. THE CONSEQUENT NEED FOR PLANNING POLICIES

The advent of large scale government intervention into health services - either by way of a service organisation financed centrally such as in Britain, or by the provision of finance through insurance (nationally or pluralistically) as in other countries - has accelerated the evolution of health care organisations into large-scale units. Health care has become a very large business with specially sensitive areas in which professionalism, ethics and emotion jostle conservatism and science; and the need for the planning of the complex services involved has made itself felt universally, not only in the more centrally managed systems but also in countries where Governments, however reluctant they have been to intervene, have been forced to regulate systems which depend on a mixture of public and private institutions. Thus in Britain, the onus for planning in the National Health Service set up in 1948 was placed statutorily on specific public appointed authorities. The same requirement for planning has made itself evident in other countries such as the

United States where it has become obvious that without some general planning system there might, for example, be a proliferation of hospital beds that went beyond the actual requirements, with serious implications for costs.

The great dilemma of course is how far such planning actions may interfere with clinical freedom and the much cherished notion in the West of the special doctor/patient relationship. The saving grace however is that planning creates its own discipline in that it requires for its formulation the production of some hard data and a framework of policy to make use of the data generated (and, indeed, through feedback to shape the kind of data required for policy decisions). But the question remains where exactly the frontier should be drawn between public policy and the practice of personal medicine.

3. THE NHS ACT: OBJECTIVES AND POLICY

There was little in the way of specific objectives in the statement of intent in the NHS Act of 1946 which gives the basic policy commitment. The assumption was that the best possible comprehensive service would be available to the population at large. Thus the Act imposes on the Minister of Health the duty

> 'to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with the following provisions of this Act ....'

There were several significant features in the Act that are fundamental to any consideration of any aspect of the National Health Service.

The hospital and specialist services were to be based geographically on 14 Regional Hospital Boards which would be responsible for planning, but the actual administration for operational purposes would be carried out on an area basis by hospital management committees, nearly 300 of which came into existence on the appointed day on 5th July, 1948.

Since, however, the specialist services would in fact be 'consultant' services made available in response to the general practitioner's specific requests, the General Medical Services were to be the primary care services. The general practitioner, therefore, was to be the linch-pin of the system, for it was to be he who activiated the preventive and after-care services to be provided by the local health authorities. This was an important principle which has many

implications. Nor was he in reality to be cut off from the hospital. The policy of direct access by the general practitioner for pathological, X-ray and other like specialist services, to widen his diagnostic capabilities and as a means of continuing education is indeed based upon this same principle. The concept therefore was a mixture of two- and three-tier systems, with interrelated but not necessarily interlocking services, with the Ministry of Health in general control.

4. PRIMITIVE PLANNING, PREJUDICES, POLICIES

Following the implementation of the National Health Service Act 1946, the emphasis nevertheless was directly on the hospital and specialist services, and Regional Hospital Boards quickly established themselves as the major planning authorities. It was they who were responsible for planning hospital and specialist services to cater for populations of about two million in the case of the smaller regions such as East Anglia and Oxford, and upwards of four million in the larger regions.

At the outset of the service there was literally no experience and therefore no literature on the planning of comprehensive services on a geographical basis, although in Britain there had been the publication a year or two earlier of the so-called 'hospital doomsday' books which set out and discussed the hospital services available in England and Wales. The hospital surveys on which these were based were carried out by teams headed by distinguished physicians jointly sponsored by the Department of Health and the Nuffield Provincial Hospitals Trust.

This policy of public/private enterprise ensured there had been no difficulty in getting relevant information and the survey reports presented excellent pictures of what services were available at the beginning of the Service in 1948, being an admirable mix of numeracy and of subjective judgement. They proved to be weak, however, on the assumptions about what was actually needed numerically by way of services, and this had an effect on the attitude of the first planning authorities who had little in the way of techniques of measurement of 'demand'(1) other than the use of not very good statistics of waiting lists. It is now evident, however, that the basis assumed, if not actually used, by the first planning authorities of the NHS for assessing the number of hospital beds required for a given population was not strong; and indeed it was not until 1960 with the publication of the Hospital Plan that the Boards had something a little more substantial to aim for. It was then that the Department of Health,

1) 'Demand' is used here advisedly rather than the concept of 'need' to which reference is made later.

somewhat tentatively, suggested that the number of hospital beds required for defined populations might be considerably fewer than was assumed at the beginning of the Service. It may be relevant that the studies used by the Department of Health for favouring lower figures than then assumed were in fact made in two areas only - Norwich and Northampton - as part of the 'Investigation into the Function and Design of Hospitals' by the NPHT and published in 1955. The chapter in this book called 'Planning to meet demand' indeed indicated that the figures calculated for Norwich and Northampton were considerably lower than those generally assumed at the time to represent the number of acute beds needed per 1,000 population.

For all its faults, this chapter virtually constituted the first real literature about planning policy that was educational in the widest sense and could be used for teaching purposes, although it was not written for this reason. Indeed, the fact that the figures were about half of assumed requirements is not only illustrative of the somewhat primitive state of the art of planning services then, but it would be fair to conclude that it was an early lesson that planning policies need constant review in the light of better information. This is specially true where resources are limited and priorities have to be established. It is also indicative of the problem of teaching an important but relatively new subject still in its development stage.

5. THE DEVELOPMENT OF PLANNING SKILLS AND LITERATURE

It would, of course, be wrong to suggest that the cadre of first administrators of the National Health Service was ill-educated for the tasks they had had to face, or had little or no administrative skills relevant to planning; nevertheless the experience they possessed had been gained in other areas of administration, private and public. The new service presented a series of unique problems of integration and co-ordination of which, in fact, no one had any experience. The administrators virtually trained themselves on the job, exchanging experiences with one another under the suzerainty of a Ministry of Health determined to interfere as little as possible. Even now there is a distinct slenderness in the record bearing on policies, notably because there has been no codification of the literature - a mass of reports of one kind or another published in the 1950s and 1960s of the large number of nationally appointed committees of enquiry as well as the more operational output of the Regional Boards and other health service authorities. Indeed these have been used to the full in the educational processes which have been developed since 1948 [see Sections V(3) and (4)].

6. THE EMPIRICAL APPROACH TO POLICIES

For the first few years the health authorities were largely concerned with trying to pursue the broad objectives set by the National Health Service Act and its accompanying regulations. These objectives were inexorably being resolved into policy elements as a result of the subsequent flood of circulars which emanated from the Department. While these were primarily for guidance, in effect they created a series of micro objectives for the planning authorities who had to translate policies into action.

The broad objective was still however the setting up of comprehensive health services in the country. This was interpreted as correcting first of all the mal-distribution of such services, by for example, looking to "under-doctored" areas, by spreading consultant and specialist services and up-grading grossly out-of-date 'plant' e.g. hospitals and equipment.

The local health authorities which were already in existence and which now had a rather more narrow function than prior to the Act (being concerned with the preventive and after-care service) had a more specific role to perform. This involved less in the way of changing the distribution of resources than in making more effective and comprehensive the health care services they were statutorily bound to operate within a geographical area.

In effect, however, it is evident that little in the way of goals and policies had been set for the National Health Service as a whole. (This still appears to be the case to this day.) The total field covered is of course immense and extremely complex and has been made more so by the original splitting of the Service - for the usual compromise reasons - into the three branches which are by no means equal in status or power.

While the hospital and specialist services are the most powerful and the most expensive, the National Health Service operation is effectively based on the primary care services provided by general practitioners (the general medical services). The solidity of the base is provided not only by the logic of a primary care service but by its conformity with the ethics of the medical profession as practised in Britain. Consultants who provide the specialist services do not in any circumstances provide primary care. In effect, therefore, no one apart from emergency cases can gain access to a hospital or specialist services without first being referred by a general practitioner to a consultant. Since most of the population is registered with the general medical services, the system is virtually made to work by its own inertia. The recovery of status by general practice after a number of years in the wilderness and the almost militant belief in its worth and course has been the result of a conscious

policy pursued by the Department of Health. The success of this policy has helped to establish the mode of practice in Britain even more strongly. Indeed such policies as the encouragement of group practice and open access to diagnostic services by general practitioners, both of which are planks in Departmental policy, are likely to strengthen the base of general practice even further. Whether the attraction to general practice has been at the expense of the quality of entry to the specialties is a moot point which is now a subject of debate: but it is questionable whether this possibility was foreseen when the encouragement of general practice was adopted as a specific policy.

The fact that the preventive and after-care services through local health authorities have required part-financing through the local authority rating system has caused the development in this sector to lag, there being a lack of incentive on the part of local authorities (not all, it must be admitted) to develop the preventive and after-care services in the way that could take some of the load from general practitioners and hospital services. The recent divorce of the social work services from the health sector, the result of a policy agreed by all political parties, was a blow to the concept of the unity of the health and welfare team and actually flies in the face of the principles behind the NHS Reorganisation Act 1973.

7. THE COMPLEXITY OF THE NHS AND THE LACK OF A GLOBAL STRATEGY

A lack of global thinking about the National Health Service as a whole has meant looseness in the development of general policies and this has been reflected in the way people are trained for different specific posts under different ministries. It is notable in this respect that the reformed NHS still does not embrace health as a whole. Thus under the new arrangements, in addition to the divorce of social work, environmental responsibility is not the responsibility of the health authorities, although the previous separation of school health services from the Department of Health has been ended.

Of course, as has been noted, the National Health Service itself is to some extent a misnomer in that, although in total it is one of the largest organisations in the world and therefore subject to all the problems of large scale organisations, it is not monolithic but made up of a large number of separate and frequently free-wheeling agencies and organisations. It is probably for this reason it has not hitherto been subject to the more stifling effects of bureaucracy. Whether or not it is as a result of a conscious policy it may well be that the provision of the National Health Service Act 1946, strengthened by the many informal undertakings on the floor of the

House about the way in which the Service would be administered, constitutes almost a classic example of how to develop a government-financed, extremely complex organisation concerned with an extremely personal social welfare service. It is conceivably no accident that its fragmented nature ensures built-in safeguards to prevent the bureaucratic abuse which is probably endemic to a centralised system.

It cannot however be too emphasised that the NHS is part of the natural evolution of health care organisation in England. At the time it was conceived, central financing was the obvious as well as the fashionable way to viability and this determined the pattern of organisation. During the first 25 years the emphasis has been on correcting the inequalities of service and filling the major gaps. It would be difficult to deny that policies have tended therefore to be makeshift to achieve the initial objectives; but if the current reformation which is now under way to rationalise the administrative structure to make better use of resources is to be successful, there will have to be more general staff thinking than hitherto with regard to an integration of macro- and micro-policies and the problems are such that the general staff concept will have to apply at the Regional and Area Health Authority level as well as at the DHSS.

III. PROSPECT

1. THE CURRENT REFORMS RELATED TO TRENDS

From what has just been recounted it is hardly surprising that the run-up to the reforms debated in the early 1970s was marked by the realisation that the three branches of the health service might be better administered as a single entity to allow for better management practice. The assumption is that this would make for a sharper focus on priorities than hitherto and consequently more rational decisions.

Yet this policy assumes the doubtful premise that, not only will there be sufficient information available on which management can act scientifically, but objectives based on clear concepts would be developed. The whole emphasis in the Secretary of State's Foreword to the White Paper on the NHS Reorganisation for England assumes that the management of the re-formed health service will be able to choose from a large number of developments or radical changes in emphasis on a fairly scientific basis. In fact, if one looks at the history of the NHS as it goes into its re-formed state, a major fault revealed is the lack of good information. This mirrors the lack of concepts about a number of important issues relating to items as diverse as the effect of different rates of capital investment and the assessment of outcome as a factor in the measurement of quality of care. This has brought in its train a lack of precision about what the new management teams will be able to achieve in practice and how they will operate.

Thus, although on the face of it the job specifications which are now available for all senior officers appear to be the educators' dream, this really masks what is actually required of the system both by way of education and training to make for better management. In fact, there has been little or no close analysis or even philosophical discussion about the way in which the new-look Health Service, conjured into existence to make better use of resources, should look at existing practice in relation to outcome as it affects the individual in the context of a comprehensive service. Yet, outside the National Health Service, no management could possibly start doing an effective job unless outcome in the particular field had

been properly analysed and understood. Indeed the question of review of existing practices in relation to the outcome of services transcends national systems of organisation, and is fundamental to any consideration of the future of health care services anywhere, for it is possible to discern worldwide moves towards the need to evaluate the quality of medical care. This takes on an urgency where limited resources force choices of priorities, not just on the margins of development but especially if the evidence, say, points to the desirability of switching resources to more attractive modes or new services.

2. THE AIMS OF THE REFORMED SERVICE

One must first of all ask what the aims of the new Service are. It would probably be generally accepted that it is first of all to unite the existing services so each part of it in any one place is managed by the same authority and the services are therefore brought together at a local level. The second is to establish what are the needs of the clients. The third is to attempt to secure a more effective use of the various resources to meet these needs when they are exposed. It is hoped this will be achieved through a clear definition of the responsibility for achieving results, and at the same time through setting standards and measuring problems. In this way it is hoped to get more effective management.

Of course there is no hiding the great extent of the problem faced by the Health Service. There are to be some 90 area Health Authorities grouped in 14 regions. The total labour force is about 800,000. There is a very large specialist organisation supporting doctors in their personal relationships with the patients, and without an effective organisation these personal relationships will not be as good as they could be. The organisation is vast and the ramifications great. If most GPs, for example, deal with only about an average of £50 a week by way of drugs, the backup of the key physician in hospital, the consultant, is something of the order of about £120,000 per annum. (The GP, of course, is the link with the hospital and social services, as well as the preventive and after-care services, but this specifically refers to resources under direct control). Together this makes for a framework and mechanism of quite a size and complexity.

There are also some natural restrictions to normal management processes. First of these is the clinical freedom of the doctors, and any management process that doctors have to take part in must recognise this. The second point is related, in as much as it is unthinkable that clinicians can ever be put into a management process in

which they are subordinate to a managerial superior. Yet the need for accountability, public and private, means that somehow they have got to be involved in the mechanism and the administration process.

3. CURRENT STRATEGIES

While the goals are still not clearly defined, it is nevertheless possible to distinguish the broad areas that have been chosen for special considerations of policy by the strategic planners at the centre. These tend to be functional in character on account of the historical priorities, the acceptance of the evolutionary process in medical care, and the lack of an overall positive strategy covering certain fundamental issues regarding quality.

This line is strengthened by the fact that the gener policy hitherto has been to regard the three basic services within the overall structure (health care services, district hospital services and the personal social services) as being three distinct entities with virtually no co-ordinated trust in an administrative sense. It was no doubt assumed that these would eventually be integrated but in the meantime, without specifying exactly how, encouragement would be given to their co-ordination.

The financial arrangement for the NHS is perhaps the key factor in favouring functional policies. The main instrument for policy reviewing is the mechanism for the financial budgeting which, starting from the Treasury, operates from the DHSS downwards. This has now been perfected almost to a fine art and is unlikely to be varied to any great extent. The general policy in the case of the major structure - the hospital authorities - has been to allow Regions within broad policy limits to plan and develop their services, and to encourage them to give the next level down /In the case of the new services it will be the AHAs(1)/ reasonable leeway for operation. The only difference in the new Service is that there is likely to be more direct guidance than hitherto in the allocations for the hitherto deprived services, for example those for the aged. The system is crude but effective. Without more sophisticated economic methods, such as input-output analyses, however, it cannot deal other than arbitrarily with problems affected by other disciplines and factors such as pay differentials and educational policies.

The same system has applied separately hitherto in the more specific case of the general medical services which are labour intensive, but the new administrative authorities may make for a different outlook towards co-ordination of action. The General Practitioner

1) Area Health Authorities.

Charter in 1965 already gave the general practitioner certain incentives to develop group practice and to make greater use of multi-purpose teams operating from health or group practice centres. These are still priorities. General practice is due for a comprehensive review of policy and currently there is a number of outstanding issues being considered by a top-level Government Working Party which is likely to lead to codification of Departmental policy.

In the case of the former local health authority services, recent years have been marked by an increase in the building of health centres, and to a large extent by local health authorities being urged to develop the preventive and after-care services, the final sanction being again the grant-aid policies. This trend is unlikely to slacken. Responsibility for total care is being placed firmly on the AHAs which are likely to develop special policies to ensure integration.

The National Health Service Act, because of its marked emphasis on the special opthalmic and pharmaceutical services(1) which bring in outside contractors such as chemists and opticians, itself introduces the idea of special services at the core of the NHS. This makes it comparatively simple for them to be kept under continuous review. In the case of the pharmaceutical services, the problem is keeping control of prescribing yet retaining the principle of clinical freedom for doctors. The centralised system of checking on drugs has hitherto been effective.

Since 1948 a category has been recognised for the special groups characterised by particular socially directed policies, namely children, maternity, the deaf, the blind and the disabled. To these have been added, fairly recently, the elderly, the mentally handicapped and the mentally ill. The first two of this trio and a large part of the third may be considered 'maintenance' (as distinct from 'acute') medicine groups. More recently, abortion and family planning policies have additionally been developed.

On the 'plant' and 'hardware' side, the stress has been on the design of hospitals to achieve maximum functional effect at reasonable cost ('Best Buy' Hospitals). This reflects the realisation of the need for a strategic capital policy hand in hand with a revenue policy.

The development of computers is a relatively recent interest as a priority in this sector. It was quickly realised that computers because of their potential (to say nothing of their emotional appeal) need a policy of firm guidance and control. It is questioned, however, if there is yet a composite policy linking computers with the development and use of information systems and the training of systems analysts.

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1) The dental service also comes within this category. It is not, however, considered in this paper.

While manpower in such a labour intensive 'industry' has always been important, it is again only in recent years that there have been moves to develop a policy for it. This has not in effect included much by way of a personnel managment policy. Because of the structure of the service, it has not of course been possible to have a completely integrated manpower policy, except possibly in regard to medical manpower, although recruitment and training are major issues in such a labour-intensive service. In the case of the medical profession, because of its long and complicated training periods and the complexity of the arrangements involving so many educational and learned authorities concerned with specialist training, the need for a comprehensive manpower policy relating educational arrangements to service has now become evident. As yet, however, there is no clear policy and a resolution of current difficulties will entail some hard bargaining between the DHSS, the universities, the Royal Colleges and the professional organisations.

It is known that the question of screening has been under review, for early diagnosis and treatment to a successful conclusion is the clinician's aim. But there has been no major thrust in this direction although the evidence suggests it is a subject to be carefully probed.

It is known that there has been some centrally inspired operational research on the macro issue of where the balance of care should be directed, for example whether the emphasis should be on directing resources to the 'domiciliary' rather than the residential services in, say, the 'maintenance medicine' group. Nevertheless, there has been little public debate so far and no opportunity for reviewing the assumptions being made in the search for this particular Golden Fleece. Reverting however to III(1) above, it will still be necessary if the Fleece is found to conceptualise how to deal with it as currency in the implementation of policy.

On the broad professional front, the first 25 years has been marked by a series of committees and commissions of enquiry concerning practically every professional group involved in the Service. In one or two cases, for example nursing, there has actually been a number of enquiries both official and private. The most recent publications on this subject were those of the Salmon Committee on Nursing Management and the Briggs Committee on Nursing. Previous to these there were many private and semi-private enquiries; but although nursing comprises the largest group numerically of the professions engaged in health services, it is surprising it has been the subject of so little significant research. In the case of doctors the most important enquiry was the Royal Commission on Medical Education.

There has actually been little in the way of implementing the recommendations on policies advocated by these Committees and Commissions or of fitting together a composite picture of the implications of all their recommendations. As an item of policy on its own this would seem desirable.

Finally, one feature of the last ten years has been the great growth in the research and development programme at the Department of Health. The main issues have been set out in Portfolio for Health and Portfolio for Health 2, and it is not proposed to reproduce them in this paper; but the fact is that this programme has hitherto been developed without an apparent link with any recognisable general strategy of the DHSS as a whole.

4. SIGNIFICANT OMISSIONS

There has been a series of omissions in what seems to be the general strategy. Some of these are surprising in view of the fact that the main feature of the National Health Service is its claim to comprehensiveness - and this, one might think, would facilitate the utilisation, inter alia, of epidemiological techniques and the practice of population medicine.

Thus for example there have been few forward projections on the effects of morbidity changes despite the fact that certain deductions can be made from data in this field and speculations made. That it is possible to do so in selected fields is illustrated by Sir George Godber's essay on the future of epidemiology in a recent publication. It is not clear whether there has been any strategic thinking centrally on certain killing and disabling diseases, for example lung cancer, coronary heart disease, venereal disease or traffic accidents. Nor has there been evidence that appreciations have been made of the possible effects of changes expected in the standard of living; or of changes that might be expected in manipulating the environment; or how to evaluate health education (which already has some priority in policy); or, to come full circle, how such education in specific directions might affect morbidity.

Again, policy is not clear as to the likely affect of developments in chemical therapy as well as medical technology. In view of what has happened in the case of tuberculosis, pneumonia, and mental health it is somewhat surprising there has been little in the way of evaluation and speculation about the possible effects of scientific drug therapy.

The effect of the entry into the EEC is also a factor about which there has been virtually no debate. Yet there are implications in this move that have a bearing on manpower and education policies.

On manpower, there has been virtually no work done on the possibilities of varying the professional mix of skills in relation to diagnosis or care generally. This contrasts with the current trend in the United States over the question of physicians assistants.

The growth and improvement of information systems for specific causes is another major subject on which much depends but for which there are so far little or no policy indications, although these are the sinews of management.

Finally, in the case of research and development, in relation to policies generally, there seems to have been little in the way of the conceptualisation and definition of problems and how to tackle them - again something that must be precedent to a new-look management.

Of course this catalogue is to be seen against the tendency of the English to be cautiously pragmatic in the development of their institutions. The National Health Service, it must be remembered, is the result of an evolutionary process speeded up by the Second World War and the social enthusiasms released following its conclusion. It is inevitable that this has given certain of its satellite institutions, developed for historical or accidental reasons, more weight than reason would allow - all things being equal; and the basic conservatism of the NHS as an institution vitiates their easy dissolution.

This principle also perhaps applies to much of the available data which for historical reasons is routinely gathered. Their collection gives a semblance of quantification of service, but the objectives for their use need sharpening if they are to have any real value. In the meantime, however, their existence if comforting to those responsible for its production, may cloud the real questions that should be asked.

Finally, although there are currently frequent references to monitoring of performance in the functions of the new authorities and their officers, there has been little or no discussion about the issues of quality control it raises; indeed, because it lies at the heart of the management problem it would appear to merit special consideration on its own. In short, if the new authorities are to fulfill their raison d'etre, which is to make better use of resources, they will require a sophistication of approach well beyond anything that has gone before and this must include the development and review of the concepts, implied as well as stated, that lie behind the idea of a NHS. It is already evident that beyond the reforms lie the objectives to probe such words as 'needs' and 'priorities' which pose many questions. Hitherto, the imbalances that have been high on the agendas of the health authorities hardly need milesticks not yardsticks for measurement; but as choices become more difficult something a little more precise may be needed.

IV. HORIZONS OF QUALITY

1. THE NEED FOR A QUALITATIVE APPROACH TO PLANNING

It is characteristic of British practice in relation to institutions to be pragmatic. Thus the British have always tended to work from the empirical to the theoretical, rather than develop a theory on which policies can be based.

To a large extent the National Health Service provides all the essential ingredients for this kind of approach in as much as it is a composite of a very extensive range of services at different stages of sophistication and development which respond to the up-to-date demands, and sometimes needs, occasioned by a wide variety of diseases. Without going into the semantics and definitions of the different kinds, it is important perhaps to stress that both 'demand' and 'need' come into the reckoning, for it can hardly be claimed that medicine in either its diagnostic pose or therapeutic action is scientific in all respects. Because of the emotional response to illness demands are set up which, while occasionally they do correspond with needs of one sort or another, are not always exactly correlated.

In the planning imperatives over the last 25 years the stress has been on getting the structure and form of services right with the aim of bringing them swiftly to those whom the planners decided were in need of them. The data and criteria used as a basis of decision were often fairly unsophisticated, and demand (often inflated), rather than scientifically established need, was the spur to action. There was little need for formal literature of a universal character. Experiences were exchanged and shared. The major requirement was seen to be a redistribution of resources and this meant almost exclusive attention being paid to the human factors and physical facilities, that is manpower, buildings, equipment and the like.

Comparisons of basic data, such as manpower, waiting lists and so on have hitherto provided the relative weights for standards of service. The fact that right from the beginning there was a restriction on money available meant that developments, which in the main tended to be marginal in effect, had to be placed in order of priority and this led to increasing sophistication in scrutiny to support the diversion of resources to particular objectives. Over the years it became evident that the improvement of plant and equipment, and even

the equalisation of manpower over population groups, are policies with only marginal effect (although that does not imply that the aesthetics of form are unimportant); so the accent has been on improving organisational patterns. The need for absolute standards of effectiveness has come increasingly to the fore since this is the proper anchor for statistical comparisons. The emphasis placed on the operational aspect is intended to make the best use of resources in a situation where there are competing priorities. But this leads into questions of quality control and it is arguable that the implication of this is likely to be the most powerful reactive agent in health services in the future.

2. MONITORING QUALITY

It has been assumed that the quality of actual care given is relatively constant, and until recently this hypothesis has not been seriously challenged. Yet fundamental to the new organisational patterns is the assumption that the reformed National Health Service will at its various levels have a better capacity of monitoring quality of services and at the same time of developing new services to meet requirements revealed as the result of the monitoring process.

There are certain basic assumptions in this. Thus, as has been recently pointed out by Sir Richard Doll, the professionals are expected to monitor their own work by self-critical observation and analysis of practice. At the same time, however, clinicians are expected to do more than that. Monitoring is an essential part of the management process but clinicians have traditionally a personal responsibility to their individual patients.

It is evident, however, that the limitation imposed by the lack of clarification of what monitoring will mean in practice at different levels in the service (remembering that the existing information systems in the National Health Service are relatively inadequate) will make monitoring rather more sinister sounding and sharply defined than it is likely to be in practice. The real questions, though, are how to decide whether services are not only efficient but effective, and who is accountable to what authority and at what level.

3. IMPLICATIONS OF THE EVALUATION OF MEDICAL CARE

In the last few years there has been some general probing in the particular area of evaluation: first on the question of screening from a scientific viewpoint and more recently on effectiveness and efficiency in Health Services. This action has brought up a number of philosophical questions on the quality of care and it is significant that these trouble others besides the British, as is particularly

evident from the literature in a number of English speaking countries. This, however, is no more than further evidence of the vast and increasing public interest in the complex field of health care and there is probably going to be much more raising of questions from outside the medical profession about the accountability of individuals and institutions concerned in medical care for their actions.

In the development of institutions there is always some point in time when groups who are likely to be most affected by possible change ought to take stock of the influence and movements to which they are subject. In the case of health services, and particularly in the context of the National Health Service, this is perhaps the stage now reached and, because the doctrine of accountability threatens the mode of clinical practice, the effect is bound to be traumatic and widespread. It is not now a matter of internal debate with the medical profession because accountability is something with which institutions have to wrestle. It is of no small relevance that in the United States which seems poised within the next few years to have a rather more publicly geared system (at least so far as financing is concerned), the whole question of 'peer' review is now very much under debate. It is not difficult to surmise that this, if not overtly, is certainly in reality a part of the recognised need for some kind of accountability being attached to a system, albeit based on free enterprise, but geared to public policies and public finance. The fundamental dilemma that will arise in any system where accountability is a fact is how to avoid the stifling effect of a bureaucratic framework (however benevolent to begin with) on the clinical freedom necessary to the kind of medical care system appropriate to modern society. This fear is sufficiently potent to cloud the issue of how far one should go in assessing quality.

4. A CLASSIFICATION OF THE CONCEPT OF QUALITY

a) Structure

As already mentioned, the elements of 'structure' in the services was the subject that was given most attention at the beginning of the National Health Service. But there are two other main categories under which the philosophers of quality tend to speculate: and if we are to understand the complexity of evaluation and the range of authorities it might be convenient to classify quality under these three main headings i.e. 'structure', 'process' (including 'practice') and 'outcome'.

Within 'structure' is the quality of physical plant and equipment required for modern health services. It also includes the organisational framework into which the services fit. In the case of the

National Health Service there has been really little change from the basic concept since 1948 and, if one assumes that the 1946 Act brought into being a rather more formalised institutional structure than existed up to that time, the 1973 Act in England can be seen merely as an extension of the rationalising processes, to make the structure fit more closely the hypothesis of medical care as a single entity. Nor is the institutional trend likely to be arrested; it certainly will not be reversed.

The evaluation of 'structure' needs little elaboration in theory. The part of quality of care dependent on 'structure' comprises not only the physical facilities available for staff and patients, but also the numbers and qualifications of the staff arising from education and training, and the form and functioning of the health service organisation. Although the levels of staff qualifications, physical structure and formal organisation are not to be equated with quality, it is evident that there is a relationship between these structural elements and the quality of care, so that, given good structural properties, good care is more likely (though not certain) to result. The end result of any manpower policy in the NHS, so far as numbers of doctors are concerned must inevitably be the establishment of staffing standards approaching geographical equality, for doctors are the key personnel and a redistribution of personnel means effectively a redistribution of resources.

The allocation of responsibilities for the quality of the elements involving service is fairly clear, but there is occasional misunderstanding of all the implications of the relationship of education to service. This is particularly so in the case of postgraduate medical training, where the educational bodies frequently proceed independently of the service bodies, and with great influences.

Clearly questions of education standards, not only at undergraduate level but also for postgraduate and through continuing education, are also key issues in this sector. Indeed it is evident that there must be statutory arrangements for the protection of the public in the matter of educational standards, and there can be no question that such arrangements should explicitly cover postgraduate and continuing education as well as undergraduate education. Looking at the range of authorities in Britain who are presently concerned in assessing quality in education and training as well as staffing standards, one begins to see the astonishing complexity of the overall problem, particularly that of the working relationships between all the bodies involved in education and service.

While it may be true that there is a beneficent Government responsible for the National Health Service, one hardly needs to be a political scientist or even an historian to recognise that there are various delegations of responsibilities from it to separate

government departments as well as to a range of statutory and other official institutions. One almost has to be a constitutional expert, however, to establish the degrees of co-ordination, if any, that exist. In the case of health services, taking the up-to-date, or rather the prospective arrangements for 1974, it is possible to identify and probably assign responsibilities for aspects of quality to all the official bodies concerned directly with health services - the Health Departments, the Regional Authorities in the case of England, and the Area Authorities. But it is not so easy to see the link-up with those other bodies, public and private, that have responsibilities for both educational and service standards (for example the Department of Education, the universities, the Royal Colleges, the University Grants Committee) nor to appreciate the growing implications of each of their interlocking functions in the general field and the reactive effects each has on the other.

When one looks at the other institutions involved in quality control of a sort, statutory or otherwise, such as the General Medical Council and the Council for Postgraduate Medical Education or, from a quite different direction, such a body as the Medicines Commission, a set of different factors is interposed. The public policy behind the existence of the General Medical Council as a statutory body is to protect the public, particularly with educational and ethical standards. How far this is to go beyond or even within education, will no doubt figure on the Agenda of the official Committee set up to consider its future: but so far as health services are concerned, because of the reactive effect of requirements of service on education and vice-versa there is surely a prima facie case for the development of a conceptual framework of quality assessment in which the responsibilities of all the bodies concerned, service as well as educational, can be tested. There is a case, too, for considering if there is need for a 'quis custodiet' doctrine to ensure, if not the co-ordination of the activities of all these bodies, at least the avoidance of confusion. Willy-nilly, this seems bound to become part of public policy.

b) Process and Practice

In the case of 'practice' and 'process' there are more subtle considerations in assessment. These are only explicable through a study of the way in which existing standards, including ethical standards of practice, have become attached to the principal processes which are the raison d'etre of structured health services - primarily those involved in the scientifically based diagnostic and therapeutic methods used in the care of a patient. (Clearly over and above the application of skills in practice there is also an 'X' factor of ability drawn from a mixture of natural gifts and experience which

cannot be measured and which is quite separate from process or even from educational qualifications).

In this context and having regard to the nature of practice, a review of the adequacy of the performance of recognised procedures can only be judged against accepted standards of practice agreed within the profession itself. Yet this assumption places some responsibility on the part of the medical profession somehow to develop nonbureaucratic and credible means to achieve this purpose. It is relatively easy to define the questions. On the ethical side, the General Medical Council (which it will be noted has a function in the category of practice as well as in 'structure') does it all the time, not always with universal approval. On the clinical side, there are simple but important questions which are being asked now rather more intensely than ever before, for varying reasons. For example, 'How well are they doing it?' or 'Where there is a choice of treatment are they choosing the best?' No one is under the illusion that it is easy to answer such questions. Yet how long, given the present trends, can all this be left out of the planning/management/monitoring process and avoid being recognised as an issue of policy of the highest importance? The ethical side of practice when acting in a disciplinary framework depends almost entirely on what is recognised as good practice.

c) Outcome

In the case of 'outcome' there is, however, a much different and more difficult series of questions. Under 'process' it may be relatively difficult but still possible to judge how well practitioners do what is accepted as good practice; but what about 'outcome'? Proven successful outcome is likely, of course, to affect practice, both in structure and process, but its assessment involves quite different approaches to the more mechanistic and measurable issues well understood by management and central to the efficiency concept. On the issue of measuring the outcome of patient care it has been suggested by Cochrane that there is a need for the measurement of the probability of improved outcome for the patients as each new procedure is added to the repertoire, together with the cost of each test and its risks. This applies both to prevention and therapy. There may be doubts about the credibility of this, but it can hardly be claimed that very much work has been done in conceptualising how much can be achieved in this area. It is however certain that few measures have been taken to determine adequacy of treatment in relation to what it sets out to do, and even doubtful whether the problem as a whole has yet been grasped. Yet this is at the root of a health service and the implications must be understood by managers and provided for in the educational and training process.

It is certainly unquestionable that ultimately the health care organisation will have to have some means of monitoring outcome and it would be foolish to ignore the inevitability of the forces that apply to the trend. Principal among these, because of government's increasing stake in health care organisation, is that of public accountability, although the demands of non-public accountability can be no less strong.

5. ACCOUNTABILITY AND ITS CONSTITUENTS

It is not difficult to see that conceptualising the issues of accountability and responsibility is a necessary preliminary to questions of 'monitoring' and this is also fundamental to questions of policy in relation to the accountability as well as allocation of resources for health services. Indeed, if there is to be any serious management emphasis and we are to have managers worthy of their salt, more consideration will have to be given to the evaluation of developments in the future. If one takes the question of, say, a screening procedure, it seems inconceivable that any government from now on will be influenced into such a policy as making available a procedure without carefully studying the objectives; and it follows that the evidence of the effectiveness of the proposals is likely to be examined in the light of the available scientific criteria. Again, and this may perhaps be the result of some central policy decision even if the particular studies are done on a regional or area basis, there may be pressures exercised in the future to monitor particular services. A particular example is to determine for the mental health service the emphasis in terms of resources to be placed on community as distinct from hospital-based services and custodial care. This appears deceptively easier than it is in practice. Indeed it would be interesting in any event to start looking at this service now by closer scrutiny of discharge and readmission rates. Again, in the case of the maternity services - the trends of perinatal mortality or the British place relative to other countries, might be a starting point; or in the case of children services, the statistics of neonatal mortality where the techniques of evaluation and the mechanisms necessary for their use are fruitless in themselves.

A major question too is at what point such monitoring should be initiated and at what level the studies would be mounted, National, Regional, Area or District? This may be an important issue likely to determine the warmth of its reception, but as a policy it also has a bearing on the kind of training required. As such, it is a question that needs much more exploration than heretofore.

In the case of the study of '<u>practice</u>' it seems inevitable that there will be more observations of whether practice is being carried

out within limits that may be defined, albeit at first subjectively. It cannot be too long before the crude study of waiting lists, duration of stay, etc. (the raw material of scrutiny) will lead on to pressures for studies of practice in greater depth.

Accreditation too is a procedural example of defining an environment by criteria agreed as being suitable for a particular type of practice. The fact that accreditation of training posts is now well on the way as an accepted policy for many specialties dependent on a wide range of criteria has a bearing on service as well as education. Yet it has not hitherto been an issue of service, and it is also certain that at some stage someone is going to have to look and see whether these policies can be harmonized - if only for their service implications.

Another example of evaluation or process likely to be forced through public pressure could be the effectiveness and efficiency of emergency services. The techniques for such a study already exist.

Indeed it is not difficult to see that one fertile sector for examination in the (Cogwheel) Divisional structures would be that dealing with operational research as a whole. A function of the Community Physician, then, will probably be to look more and more at what can be done by way of evaluation of acute services relative to effectiveness, if only to determine the priorities for future development.

Of course the third factor, '<u>outcome</u>', poses the most difficult problem as a real issue of accountability, but the question is whether we are still too far from the stage when it may be possible, albeit cautiously, to begin a more definite series of controlled clinical trials on the effectiveness of specific treatments. This is not an easy thing to accomplish. It might however be possible to draw up a shopping list of subjects to see what is involved. Above all, it seems there has to be a policy for a national strategy with roles for bodies at national as well as local level, for the Medical Research Council, the new Chief Scientist organisation at the DHSS as well as the (Cogwheel) Medical Executive Committees in association with the community physician.

Indeed it is not difficult to see the development of such a strategy as necessary for future policy. There has existed in the United Kingdom for a long time the Maternal Deaths Enquiry in which outcome is used as the triggering factor to enquiry and action. In effect it is a good example of how a centrally-based enquiry can affect practice, for at each clinical stage the enquiry consists of an exhaustive examination to determine what is avoidable with recommendations for altering arrangements of practice; and it is reckoned to have been a success in reducing maternal mortality. As such, it seems likely to be something to build upon for the future.

At local level, the technique of the regular 'deaths and complications' meetings and the autopsy report are clearly educational means as well as a mechanism and tool of management.

What seems essential, however, is to recognise the implications of the discernible trends. It is evident that the evaluation of practice can only be effectively carried out from within the profession itself operating in close association with, though not always necessarily part of, the NHS organisation. It has, of course, to be associated in some way with the system because it is only through the system that action can ultimately be taken.

It is therefore important to explore a theory of health service operation as a precedent to an educational strategy because it is only by this that one can test the effect on the whole system of actions in the several sub-systems which already exist.

This is specially important when one comes to analyse accountability and the functions of the several authorities responsible for evaluation. The philosophical objective must be a method that is non-monolithic and as self-regulatory by the medical profession as possible: but unless this is seen to be effective it is unlikely to be accepted by the public as represented by their Members of Parliament, who are bound to become increasingly interested. As has been indicated earlier, it is notable that in the United States the battle is presently joined with the objective of making a peer review system mandatory through the application of sanctions that can be applied by public bodies - irrespective of any action that can be taken through the courts. With its National Health Service, is the United Kingdom likely to lag far behind in this?

Yet it is not a subject that is yet deemed an important enough matter of policy to affect the future shape of the NHS. On the other hand, this does not mean that nothing is likely to happen. In the United Kingdom there is a number of independent bodies, some of them unofficial, who have the capacity and standing to take part in experimental exercises dealing with research and development, and sometimes education. Nor is it in their tradition to wait for national policies to embark on exploratory ventures. Indeed some of the studies would be the better for being looked at experimentally by the professional bodies. The best course would be if public and private encouragement were given to selected bodies within some general strategy to stimulate action, to look at some of the major issues. The Royal Colleges and the Specialist Associations will have to have a major function in this line of approach, but it must be admitted it is not as yet within their view of current affairs.

6. PEOPLE AND INSTITUTIONS

With this background in mind there are various areas which have to be explored, precedent to a programme of possible action.

The different groups concerned in the evaluation of quality are the general public, the politicians, the members of the Health Authorities, the administrators, the community physicians and the clinicians themselves. The administrators, and to some extent the politicians, can be placed in two broad categories: those whose major thrust is action and those concerned with the development and testing of policy that precedes action. This is also particularly the case, in so far as the new arrangements are concerned, with the relatively new breed of health service research administrator who has an important link function in that he is concerned with exploring with the 'action' groups what the problems are, and with conceptualising the issues to determine where to put the main resources available in order to achieve results.

The public are an important outside influence to action, in as much as they are increasingly becoming aware of the fact that medical practice is not always scientifically based. This is reflected in frequent Press comment about quality, especially in the more serious newspapers and journals.

The politician is quickly becoming aware of this trend, and since the public are his constituents and because nowadays he wishes to be well in advance of public opinion formation, he is concerning himself with quality more than before. But, because he sees only vaguely how systematic evaluation can come about, it is evident that some simple conceptualisation which he can understand will have to be made for him.

This requirement probably applies also to members of the Health Authorities as well as to the administrator, but in the latter case one of his main functions is to see that the members of his authorities understand their own roles as well as those of the authority. He must also ensure that the mechanisms for evaluation are adequate, that they turn over properly and are maintained, and that they are given the right power drive. Beyond that, the administrator has to have a grasp of the niceties of those things that are his direct responsibility to ensure their effective working, and those things requiring, say, clinical judgement that must be secured from outside his own personal knowledge but within his administrative network. Thus, if it is agreed that peer review arrangements, or even complications and death meetings, should be a part of the mechanism, his management function requires him to see that they actually take place. It is arguable that this kind of administrator should be medically qualified, but it is no means certain that he need be.

The community physician has also to be sure about his function because he may be an epidemiologist or a medical administrator, or he may be a hybrid: but it is evident that he, too, should stick to his particular last, which in this connection is to facilitate the means of review for the clinician.

The clinician presents the most difficult problem in that, while he may accept in principle the need for evaluation of practice, he tends to be rather busy practising medicine. Since the kind of evaluation needed and the mechanism for the discussion in question tends to be time-consuming, it is easy to make a strong case for doing nothing or relatively little and rest on the assertion of a personal responsibility to his patient. Yet it is notable that, because he is part of a service, if he were obliged to take part in such an activity as peer review, in any form, the mandatory requirement confers on the administrator a special role and makes him accountable too.

In the case of institutions the problem is how to develop a comprehensible philosophy of approach to common problems and an inter-institutional relationship in which responsibilities are clear. There should also be no clash between separate institutions working on different tasks and pursuing what could well be irreconcilable lines. This is no small order; but the list of institutions, official or unofficial, that have a bearing on management practice and outlook in relation to evaluation is formidable. It includes the Health Departments, the DES, the Regional Area and District Authorities, The University Grants Committee, the General Medical Council, the Royal Colleges, the Council for Postgraduate Medical Education, and the Medicines Commission, to name only some. While we are not really concerned here with the elements to be evaluated in the category of 'structure', it is evident that there must always be danger of a clash between the service authorities and educational institutions over such a matter as accreditation simply because they may each be operating with quite different standards.

It cannot be stressed too much that use of comparative data is bound to lead on to questions about the adequacy of 'process' and 'practice' and 'outcome' and this must lead on to a demand for better information.

7. MEANS TO THE END

The means to this are studies drawing on existing data or prospective studies designed to explore certain ongoing issues. The limitations of existing data are too obvious to dwell upon. To make these exercises credible and effective, there really has to be some general staff thinking about the improvement of existing information and the

direction the studies must take, and it is questionable whether such an operation exists anywhere in the National Health Service. If the answer to this question is indeed negative, it would be useful to explore how to set up such a function and where in the general strategy various institutions and individuals concerned fit into it.

As far as continuous monitoring of quality is concerned, it seems evident that it will be important to try and develop some form of mechanism for review of practice at the hospital or district level; but unless concepts can be successfully agreed upon professionally it is unlikely that a mandatory scheme can be brought into being. Even where there is some agreement about the usefulness of some procedure, there seems from the evidence no certainty of its being carried out voluntarily.

8. MECHANISM, STRATEGY AND TACTICS

The mechanism for these studies lies first of all in the administrative arrangements which exist, either in the health service authorities or the external bodies that concern themselves with health service issues such as, for example, the universities and foundations. At national level the emergence of the post-Rothschild arrangements at the DHSS (in association with the MRC) is a novel factor and its potentiality is intriguing. It is possible to conceive of certain studies being mounted at regional or area level; but it is not so certain that, despite the emphasis on management for the future, the operation will be geared to what will in effect have to be a revolution in thinking, unless there is some guidance and external pressure for studies.

In general, it seems unlikely that there is, or is in immediate prospect, any official strategic or tactical thinking on the subject of evaluation of quality. The strategy would seem to be to develop a series of studies and indicate the necessary mechanisms, and then to educate the public, the administrators and the professions to the acceptance and use of such mechanisms.

The immediate tactics would seem to be to conceptualise the issues and set them out, and thereafter indicate the administrative and professional levels where the quality controls should rest, and develop some scheme of action for 'selling' the idea of evaluation. This will almost certainly involve a series of studies, experiments and demonstrations, which while seemingly precedent to, should be used as part of, an overall policy and strategy.

The individuals most strictly concerned in both strategy and tactics are the administrators and the community physicians, who will lean heavily on the techniques of community medicine, and the emer-

gence of the 'group' qua 'patient' seems bound in the long run to affect fundamentally current concepts of medical pratice which is based on an exclusive patient/doctor relationship.

Indeed the key figure in the post-1974 National Health Service may well be the community physician, whose future status as measured by income is to be equated with that of the clinician, a policy from which much will undoubtedly flow. The fact is that community physicians have been trained basically as clinicians to approach problems in a sequential process, viz to take histories, to examine the patients, to call for scientific tests, to judge the conditions, to prescribe therapies, and to observe results. This, coupled with recent improvements in the techniques of measurement in terms of epidemiology and operational research, cannot fail to have an effect when they look at medical care and its planning. The potential influence of the specialty will go well beyond the activities of the old style Public Health operation and beyond the amateurish kind of planning that has existed hitherto. It will particularly flourish in times of economic stringency and in response to calls for greater public accountability, since it promises to provide a means of greater control of performance and so for the setting of priorities. This means a special urgency for developing high quality arrangements for the training of future community physicians, not only in the use of techniques and the presentation of results, but in this semi-scientific age as perhaps the key all-round members of the planning teams.

V. RECONNAISSANCE ON THE EDUCATIONAL FRONT

1. 1974 AND AFTER

The fitting of health care institutions into a large-scale organisational framework inevitably brings certain changes in train. Above all, doctors of all the specialties as well as those concerned with the management of health care institutions, either as members of authorities or professionals, have to realise that focusing on the principle of accountability will bring in its train procedures that will not necessarily impinge on the essential clinical freedoms but may be restrictive in other senses. Whether any system, and in particular the new one in Britain, can in fact provide for this without a well-balanced educational effort to give a sensible orientation to those participating in it, is a matter of immediate concern.

The vastness of the health service organisation thought necessary to meet the expectations of modern society threatens its effectiveness; size leads to layering, to insensitivity, to bureaucracy and to remoteness. It is not difficult to see that the increasing demands for services which seem limitless is bound to lead to even greater activity in the business sense, to greater pressures for closer integration and so to make better use of limited resources. To achieve this without abrasion which is self-defeating the management strategies and the tactics have got to be right; and fundamental to these too, are the appropriate concepts of education for health services that fit the needs. If there is to be unified service there must be a sensitive understanding of the teamwork required. This must, in fact, be the mainspring of the strong management mechanism that is planned and it will require the processing of a steady flow of appropriate information from many sources served by different disciplines and professions. The fact that strong teams are to be put together at district level raises a whole series of additional imperatives in training to co-ordinate the disciplines that apply at top level. There are also fundamental questions which have to be faced sooner or later. Is it indeed possible in effect to segregate too severely the professional training of the individuals who are going to be part of the team. If the basic disciplines are distinct, at what point and how are they to merge? Is there to be

common training and if so at what point of development? Whatever the answer, it is bound to affect personnel policies which have got to include a well thought-out educational policy to help ensure the co-ordination of the professional components of the management structure.

2. IS THE EDUCATIONAL SYSTEM GEARED TO THE TASK?

How does the educational system, composed as it is of a variety of satellites, independent institutions, match up to the immense requirements any survey, however brief, reveals? If it is inevitable that the loose gearing of the system takes time to catch up in a developing situation with the needs perceived at any one time, how significant is the delay likely to prove? Further, if as has been argued there are marked trends that stem fundamentally from the key issue of quality and add up to a challenge of accepted practices, what is its significance in educational terms? In view of the recent history of educational effort in relation to health care organisation which indicates a slow evolutionary development borrowing heavily on the past, does it matter at all?

3. CURRENT FORMAL EFFORTS

In terms of formal professional education, leaving aside the question of quality of content, the facts are relatively simple.

On the medical side the medical officers of health, unlike their fellows in general practice or the hospital or the specialist services, have specific and statutory responsibilities under the Public Health Acts, and this is reflected in the qualification they must possess. Indeed the postgraduate diploma, the Diploma of Public Health (or one of its various modern equivalents) is still the only postgraduate specialist qualification statutorily registerable with the General Medical Council.

On the non-medical side the main professional qualification recognised, but not essential for the holding of any post, is that awarded by the Institute of Hospital Administrators after examination. The candidates, like most others for professional awards, rely on preparatory courses either at colleges or night schools or by correspondence.

Thus, apart from the long-standing DPH Course (or the MSc courses which in certain places have replaced them), there have been virtually no university courses for higher degrees in health services that could be claimed to have had a part in the education or training of the present breed of health service administrators. (The same applies

for that matter to first degrees with the exception of those very few university degree courses for nurses which in any case are still in the experimental stage.)

4. CURRENT INFORMAL EFFORTS

On the more informal plane, it is not easy to judge the effect on the service of the ventures that until fairly recently have been predominantly the result of non-health service enterprise.

The Staff College of the King Edward Hospital Fund has privately organised staff college type courses for selected hospital administrators since the beginning of the NHS and their content has been modified over the years to take account of current developments. Subsequently, with the University of Manchester and later the University of Leeds, the Staff College broadened its approach and, from its inception, has taken part in the official National Training Scheme for Administrators which involves the selection of both in-service and out-of-service candidates for entry into hospital administration and followed by short periods of staff-college type training, complemented by an apprenticeship-type of in-service training.

In the last year or so, however, certain universities and polytechnics have co-operated in a deliberate policy of the DHSS to encourage the setting up of short staff college-type courses primarily concerned with the re-orientation of personnel to the reformed NHS.

In view of the shortness of such courses and the haste with which the programme has been mounted, it would hardly be surprising if such efforts proved to be of little educational value beyond morale-boosting.

This is not to decry ventures of this character that aim to give orientation and indoctrination, for these are also largely the objectives of the activities promoted at Regional level by the Regional Training Officers for middle or junior management and supporting staff, making use of further education institutions and techniques. But without a framework of comprehensive policy there is a danger that the fragmentary approach and the inevitable lack of consistent policy and follow-up will prove frustrating to participants and organisers. The success of the Regional Training organisations in general in mobilizing local educational resources for their albeit limited objectives must not be lost sight of, and no comprehensive policy can afford to ignore its lessons both for education and training.

In this respect 'education' is described as 'the process by which an individual is encouraged to develop the powers of his mind, to discover, to assimilate, to criticise, and to synthesise', while

'training' is defined as 'the perfection of skills, of patterns of reactions to situations that can be anticipated frequently to recur. Training implies that certain tasks shall be done frequently and under critical surveillance. Learning by doing is essential to training'.

5. DEFINING THE SCOPE

This raises the question of the need for some definition of the educational objectives. Who are the clients? Do they fall into recognised groups? What are the various individuals being educated for? What is to be done by way of education and what by training? What scale of operation is necessary? What is the level of training that must be developed? A subsidiary but important component of the education and training problem is, of course, recruitment, because it is here that questions about the required levels of intellectual capacity and time scales arise.

In the matter of what is required and for whom, there has clearly first of all got to be training for the professionals - the managers, the planners, the people who are concerned with resource allocation; and of course the operational people at all levels, including those whose basic tool is epidemiology. There are however other groups, in the non-staff category - the members of Health Authorities and the clinicians - who have to have orientation. There is also a major educational job to be done in the wider sense with the politicians and the public.

The case of who should be trained turns on the policies for recruitment and professionalism. The job specification largely determines the kind of intellectual quality required but, assuming one portal of entry into each category which has been the case till now, at some stage or other there must be streaming of quality for higher training. (In general, however, this paper is concerned mainly with the senior management stream rather than with middle and junior staff.)

6. GROUPS TO BE TRAINED

There is thus a variety of groups who have to be educated and trained. The NHS is vast and complex, and it is managed at different levels (and even within any one level or sub-stratum) by many different types of administrators, with quite separate avenues of approach and advancement.

One obvious line of division seems to lie between the medical and non-medically qualified administrators. This, however, can be

a dangerous oversimplification, for there are various categories and sub-categories of operational activity which involve the crossing of disciplines, professions and different specialties while the basic discipline is relatively unimportant. Indeed, the mix of relative responsibilities and functions depends on the operating level and often the authority.

On a different and broader tack, the educational and training task can be broken down into pre-entry, post-entry or postgraduate, and continuing education which includes arrangements for the non-professionals. This classification can be fitted to the levels and the scale of educational operation necessary. Until recently there has been little by way of guidance as to the administrative content of posts which, of course, determines the various skills required. The introduction into the administrative mechanism of the Medical Executive (Cogwheel) Committees which are composed of clinicians complicates the matter further, because the particular mechanisms through which these groups of clinicians work require direction and power-drives which have to be geared to optimising the composite strengths of the group for its function in the decision-making process, in recommending priorities and such like matters. Thus the support needed for the clinician groups could run along epidemiological as well as administrative and financial lines. The kind of analysis and differentiation of needs which logically might precede the design of training courses for these group members would, therefore, have to go beyond formal categories of job descriptions into questions of job evaluation and involve a fairly deep analysis of the decision-making machinery, which is currently in process of change, still without there being a clear picture of where real responsibilities lie.

It is evident from the job descriptions circulated when the new administrative posts were advertised recently that an attempt has been made to relate these to the aims and objectives of the various authorities. This is perhaps the first time that the educational and training authorities have been able to examine what is needed by way of training to make for a reasonable homogeneity in the several classes of individual to be trained. Yet this is essentially for the long-term. The first administrators of the reformed NHS have other needs, and it is not clear if these have been exposed. But whether or not it is going to be possible to monitor and evaluate the large number of courses, admittedly of a short duration, which have been set up to cover the interim period before the start of the new health service is a moot point. Yet it ought probably to be done as objectively as possible if appropriate lessons are to be learnt and applied.

7. THE PURPOSES OF TRAINING

If one turns to the purposes of training, the policies being pursued are seen to cover (i) orientation; (ii) indoctrination; (iii) appreciation; (iv) accelerated experience; and (v) instruction.

While (i) and (iv) really come into the continuing education bracket, (v) covers the pre-entry and graduate period and therefore has a more long-term implication. There is still no policy for sustained pre-entry training for the managerial side of the health service, although there is in-service training under the National Training Schemes which might be classified as 'pre-entry'.

In effect, most of the current effort designed specially for the changeover phase covers the policies (i) to (iv) and is directed towards particular groups, primarily the lay administrators and the community physicians, although it includes provision for clinicians (both consultants and GPs) likely to play a part in the medical executive committees, nurses, and senior members of the technical professions. It also includes some short courses at least for 'orientation' for the membership of the authorities.

8. CONTENT

In the matter of content, concern must be again with the aims of learning, of education and training. What is fundamental is an understanding of the system, of the behavioural constraints, of the social context, of the level of performance looked for, as well as a grasp of the techniques available and, above all, of the implications of quality control.

This adds up to quite a substantial list of requirements if the process of integration and reorganisation is to be effective, but, it must be possible to construct a general framework from it that provides a recognisable disciplined approach.

The main management subjects that should be included have been discussed recently by Professor L.A. Gunn in Challenges for Change. The ones he suggested to cover the whole range of issues, were:

i) Organisation Theory.
   -a. Classical themes.
   -b. Human relations themes.
   -c. Systems themes.
ii) Personnel Management.
iii) Information Management.
iv) Decision Theory.
   -a. Investment appraisal.
   -b. Cost-effectiveness and cost-benefit analysis.

-c. Network analysis and operational research.

-d. Other quantitative methods, etc.

v) Financial Administration.

It is possible however to classify the essential subjects in terms of management functions:

e.g. 1. Information Management.

-a. Including 'systems' aspects of organisation theory.

-b. Including operational 'research and intelligence'.

2. Financial Management.

3. Analysis of Structures and Operations.

-a. Including classical organisation theory.

-b. Emphasising applications of operations monitoring and control, long-range planning, etc.

4. Decision Making.

-a. Mainly the economics of choice (investment appraisal, CBA, etc.)

5. Management of Human Resources.

-a. Including human relations aspects of organisation theory.

-b. Much of personnel management.

The various training packages that could be provided for defined categories of administrators should probably, therefore, consist of different combinations of these subjects at various levels, plus some textual material on the public sector generally and the NHS in particular. It should also, perhaps, be a requirement during training for the students to work in depth on some particular topic (e.g. the application of certain techniques to the management of Out Patients Departments.)

It is not proposed to discuss this further in detail but it may be significant that the newly founded Faculty of Community Medicine has been exploring the kind of subjects required for the general training of the community physician in the future. It seems that the principal of these, which would form the basis for membership of the Faculty, should be epidemiology, statistics, social sciences in relation to community medicine and the principles of administration and management. It is likely that in varying proportions these subjects would also provide the basis of any graduate or professional course designed to produce the managers at top level.

9. THE SPECIAL CASE OF 'R AND D'

The training of research personnel presents a special problem at this time because they will not only be concerned with pure research but in the increasingly important 'R and D' field, turning

out material for management. In one sense the vastly expanded programmes of health services research and development which have been a feature in Britain over the last ten years can be regarded, at least in part, as training facilities for researchers. The next stage is likely to embrace a rather more formalised programme to evaluate 'R and D' (and the quality of its practitioners) as part of the research strategy. The Medical Research Council, with its tradition of high standards and the experience it has already had of training in the biological sciences, could clearly be a key institution if it participates, as is likely, in the general 'R and D' strategy. Once again, however, the matter of training is closely bound to that of recruitment and, without an overall policy with regard to career structure in the area of Health Services R and D, there is bound to be a lot of frustration on the part of the individuals who have been attracted to this field but find themselves at a dead end.

10. THE PLACE OF THE INSTITUTIONS

Where does this leave the educational institutions? It must be accepted that education in the widest sense must prepare students for all kinds of eventualities. It must also have provision for technical education as well as training for specialty requirements. In the case of the management of health services the problems faced by the administrators of the new health service are coming to the identified at each particular level. As has been noted, the circulars for the appointment of the regional, area and district personnel include broad job descriptions which presumably will be taken into consideration in developing any educational thrust. At the same time, however, none of these job descriptions ever seem to hint at the need for the kind of far-reaching conceptual approach that is set out, for example, in Sir George Godber's essay 'The future of epidemiology' in the book The Future and Present Indicatives. Nor is it really so much in practice a question of conceptualisation as an attitude of mind towards the total problem of ill-health in any society. The question must be asked, therefore, how far educational policies can be developed to fit not only the requirement of a complex on-going service the immediate objectives of which include the improvement of existing services by streamlining, but the change in thinking, and indeed tempo required, if the reformed National Health Service is to be a positive offensive force. If quality assurance, for example, is to be a key management issue, how can the necessary attitude and style be brought into the postgraduate training of doctors? At the same time, how can a slightly different kind of thrust but in

the same general direction be developed for administrators and community physicians as well as for those who are to be members of the health authorities at each level? Altogether, there is clearly the need for some strong action to cover the immediate post-change period, but extending beyond it to ensure continuity.

This indeed is the challenge: to formulate a comprehensive educational policy designed to orientate all the personnel towards the opportunities an effective health service can provide to make the best use of resources for the development of therapeutic services, and to institute preventive measures which in the long run are all likely to prove more efficacious than the interventionist measures involved in therapy.

While it is easy to see the place of the short indoctrination seminar-type of course for the present it should not be lost sight of that there is likely to be a period immediately post-1974 for which there should be special preparation now. Certainly no young administrator or community physician being groomed for major responsibility should be allowed to learn only on the job or should have to rely on occasional indoctrination seminars. There must be special facilities brought into being, not only for basic education and training, but also for development training - first of all to instil some ideas of the way in which skills and techniques can be applied to the overall aims of today's complex health services and, in the case of development training, to bring out the latent abilities of those selected for higher things. This calls for a deliberate policy and plan for the immediate post-1974 period, based on an appraisal of the trends which are the resultants of current policies.

We are however, thrown back on the need for a comprehensive picture of policies at each level national, regional, area and district and the requirement for the development of a literature which will exhaustively analyse the educational requirements of management with an appropriate niche for clinicians.

VI. REVIEW

The organisation of a National Health Service to meet the aspirations of 50 million individuals is extremely complex, and the problems of provision both of service and education reflect this.

Quite apart from the effects of the uneasy compromises that abound in the National Health Service, occasioned by its evolutionary development which has thrown up occasional oddities in mutation, there are also undoubted difficulties in developing a rational educational policy arising from the broad sweep of authorities involved. It would be over-cautious, however, to wait for a satisfactory rationalisation of the administration of the health care organisation itself before initiating certain positive actions in relation to educational policy.

There is ample indication in the British experience that outside influences can affect official policies, but in many cases these need catalysts. It is certain that one of the strengths of the British system is its extreme heterogeneity. This extends into the field of responsibility, organisations that are not of the National Health Service being often extremely important to its administration and development and, above all, to its balance. This is no less true of the corresponding educational system, the intricate gearing of which to the requirements of the National Health Service is a matter too important to leave to chance and ad hoc local development. The factor of extreme heterogeneity tends to complicate not only the Service but the associated educational policies. What is missing is a general theory in which all these several parts are demonstrated as playing specific roles in the total system. It would probably be a worthwhile investment to see whether such a theory can be put together with the appropriate models to reveal where the weaknesses in current education lie in relation to service requirements.

It is not suggested this is a simple operation but a successful result is probably essential for determining long-term policies in service as well as education. In the meantime, however, there are certain avenues that can be explored in pursuit of a realistic education policy. The major of these are concerned with the various issues which have been ranged over in this paper.

If the reforms in the Service structure are to mean anything positive they will be precedent to moves towards a more offensive operation in regard to the National Health Service than hitherto. In this the major stresses would be on reviewing preventive measures, while at the same time looking more closely at the quality of care in its preventive, therapeutic and maintenance aspects. The administrative arrangements of the Service in its post-1974 phase are intended to ensure that these questions are properly dealt with, but there is at the moment no onus on the educational authorities to assess the provision for basic professional training as well as post-graduate and continuing education in order to fit it better into the service requirements, and no sign of a policy on the part of the Service authorities to inspire the educational authorities. On the other hand, there may be an obligation on the educational authorities to consider future policies in the light of trends, for there is clearly a major educational job to be done to inspire those involved with the new Service with the notion of extra dimensions. Thus it would doubtless have to mean a widening of horizons for the higher educational authorities, particularly the universities.

In the absence in Britain of the special focus provided by Graduate Schools there may be a strong case for the development of one or two special ventures - perhaps in the form of institutes within selected universities - concerned with education and training in relation to service policies and the objectives of the National Health Service. It is probable that any study to develop a theory and models, as has been suggested in this section, would point to the need for such centres.

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